TS0042_04

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman of an Investigation into a complaint against:

Lanarkshire Acute Hospitals NHS Trust (the Trust)[1]

Complaint as put to the Ombudsman

1. Mr C's wife, Mrs C, was referred to Hairmyres Hospital (the hospital) by her GP on 16 February 2001 for investigation of recurrent bouts of iron deficiency anaemia. The account of the complaint provided by Mr C is that on 26 February 2002 his wife, who was diabetic, was admitted to the hospital. On 13 March 2002 she was diagnosed with cancer of the colon. On 19 March she underwent surgery to remove the cancer. After her operation Mrs C was cared for on a surgical ward (Ward 2) then transferred to another surgical ward (Ward 5) on 28 March. On 19 April she was transferred to a medical ward (Ward 9) and to another medical ward (Ward 10) on 26 April 2002. Post-operatively she developed a number of complications including pulmonary infection, severe hypoalbuminaemia (low albumin level in the blood), heart failure, mouth infection, persistent diarrhoea, pressure sores and oedema of the limbs. Mrs C's condition deteriorated and she died in the hospital on 7 May 2002.

2. The matters subject to investigation were that:

   (a) there was an unreasonable delay in diagnosing Mrs C's cancer; and

[1] Lanarkshire Acute Hospitals NHS Trust was dissolved under The National Health Service Trusts (Dissolution) (Scotland) Order 2004 which came into force on 1 April 2004. On the same date an Order transferring the liabilities of the Trust to NHS Lanarkshire came into effect.

(b) Mrs C's postoperative management, and the recognition of postoperative complications, were inadequate, including but not limited to, that:

(i) she was not considered for admission to the High Dependency Unit in the early post-operative period;

(ii) nursing staff failed to ensure that she was provided with adequate post-operative nutrition and adequate mouth care and failed to manage her fluid balance optimally; and

(iii) nursing staff failed to arrange input into Mrs C's care by nursing specialists in diabetes or colorectal cancer.

Local resolution

3. Mr C complained to the Trust on 15 June 2002 raising a series of concerns. A meeting was held on 17 July and the Chief Executive of the Trust responded formally to the complaint on 9 September 2002. Mr C remained dissatisfied and a further meeting was arranged for 4 November 2002. The Trust agreed to carry out further investigations and then wrote again to Mr C on 28 November. Again Mr C remained dissatisfied. The Trust indicated that there was nothing further they could add to their previous comments. Mr C asked for his complaint to be considered by an Independent Review Panel but that was refused on 28 April 2003. On 13 May 2003 Mr C then asked the Ombudsman to consider his complaint. The Ombudsman decided to investigate the aspects of Mr C's complaint set out above.

Investigation

4. This office wrote to Mr C and the Trust on 23 December 2003 setting out the matters we proposed investigating. The Trust's comments were obtained and relevant papers, including Mrs C's medical records, and correspondence relating to the complaint were examined. Two Professional Assessors, a Consultant General and Colorectal Surgeon and a Senior Nurse, were appointed to assist in the investigation. Their reports are reproduced in their entirety at paragraphs 23 and 24. The Ombudsman's

staff took evidence from four members of the medical staff and eleven members of the nursing staff involved in Mrs C's care and from the Associate Director of Nursing. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. The medical terms and abbreviations used in the report are explained in Annexes A and B respectively. Annex B also explains the role of staff involved in Mrs C's case.

Sequence of events

5. The sequence of events was as follows:

16/2/01 Mrs C's GP referred her to Consultant 1 at the hospital for investigation of recurrent iron deficiency anaemia.

17/4/01 Consultant 1 reviewed Mrs C at an outpatient clinic and placed her on a waiting list for flexible sigmoidoscopy and barium enema.

6/5/01 Consultant 1 went off sick.

22/6/01 A barium enema was carried out.

10/7/01 A colonoscopy was attempted.

25/7/01 Mrs C was admitted as an emergency under the care of Consultant 2 with symptomatic anaemia.

27/7/01 Mrs C was discharged after a blood transfusion. Her discharge document includes '… she had a colonoscopy two weeks ago and … there were poor views due to inadequate bowel preparation and it needed to be repeated … she has follow up arranged with [Consultant 1] …'.

8/8/01 A doctor in the Gynaecology Department wrote to Consultant 8 enclosing a copy of Mrs C's discharge summary and included '… no medical follow up has been arranged due to her ongoing investigations with [Consultant 1]'.

Mid August	Consultant 1 returned to work.
2/10/01	A gastroscopy and a repeat colonoscopy were carried out.
15/10/01	Mrs C's GP referred her to the Gynaecology Department at the hospital with vaginal bleeding.
16/10/01	Consultant 1 referred Mrs C to the Haematology Department and included in his referral letter '… colonoscopy was … free from disease. There had been a suspicion of terminal ileitis but biopsy showed this to be normal colonic mucosa …'.
14/11/01	Mrs C was reviewed by Consultant 3 who considered that her iron deficiency anaemia was undoubtedly from the gastrointestinal blood loss and suggested that the surgeons consider the possibility of an inflammatory bowel disease.
19/11/01	Mrs C was reviewed at the gynaecology outpatient clinic and referred for an ultrasound with a plan to review her in six weeks.
28/11/01	Consultant 1 wrote to Mrs C's GP, with a copy to Consultant 4, advising that the colon was clear and that he would review Mrs C following the result of her gynaecological investigations.
17/1/02	An ultrasound (arranged by the gynaecology department) was carried out and reported as negative.
24/1/02	A note in Mrs C's gynaecology records says '24.1.02 [Patient] advised by phone – no review as no bleeding. For referral for hysteroscopy if bleeds again'.
26/2/02	Mrs C was re-admitted as an emergency to Ward 3 under the care of Consultant 5.

28/2/02 A CT scan confirmed an abdominal mass. Mrs C was transferred to Ward 2 (surgical ward).

13/3/02 A repeat colonoscopy confirmed a large tumour in the right side of the large bowel.

19/3/02 Mrs C underwent surgery to remove the tumour.

28/3/02 Mrs C was transferred to Ward 5 (surgical ward).

19/4/02 Mrs C was transferred to Ward 9 (medical ward).

25/4/02 Mrs C was transferred to Ward 10 (medical ward).

Evidence of Mr C

6. In correspondence during the Trust's investigation of the complaint and with this office, Mr C said:

> *Letter to the Trust dated 15 June 2002*
> 'My wife … was admitted to Ward 2 … on 18 March 2002 and *operated* on for bowel cancer on the 19 March. Despite assurances by the surgeon [Consultant 5] that "the operation was a success and she would make a good, if slow recovery", she died on 7 May 2002 in Ward 10.
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> … I believe that her death was due to poor nursing management in *Ward* 5 [28 March to 19 April] which varied from incompetent to dangerous …
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> My wife developed a serious fungal infection in her mouth 3 days after her operation. Nystatin was applied from the next day, but Diflucan treatment was not started until 5 days after the initial Nystatin treatment. The treatment was haphazard and it was only when my wife was transferred to Ward 9 on the 18 April that a concentrated effort was made to deal with the infection by swabbing and applying Nystatin every hour … attempts were made to identify the source of the infection but all that was achieved was

that the Diflucan treatment was stopped. Even at the time of her death the infection had not properly cleared up.

Because of the mouth infection my wife found it painful to eat. A dietician came to Ward 5 and outlined a feeding regime that involved supplying "Build up soups, easily assimilated main meals and calorie rich ice cream". Within the next fortnight a farcical situation developed where either no soup would be sent up or no main meal or no ice cream. While this farce was taking place, my wife was becoming seriously undernourished; eventually I threatened to report this incompetence to you [General Manager of the Trust] but my wife was moved to Ward 9 the next day. … I became so concerned about my wife's lack of nourishment that I prepared microwave meals at home and brought them in at midday to ensure that she got some sustenance. Added to this, most lunch and tea times I had to go to the hospital shop for ice cream for her because the promised ice cream was not sent.

While in Ward 5 my wife developed an upper chest infection. A sample of her sputum was taken to try to identify the source. The day she left Ward 5 the sample of her sputum was still left standing uncollected on her locker …

My wife was eventually placed in Room 3, Ward 10. While she was there I became so concerned with the filthy condition of her room that I brought in a brush, dustpan and duster. I swept up the fluff from under her bed and the dirt and debris from the floor. I removed dust from horizontal surfaces – particularly bad were the tops of the electrical trunking and collision bar behind her bed. I treated the work surfaces with bactericidal spray and used wet paper towels to try and clean off dirty black marks on the floor …'.

Letter *to the Trust dated 12 August 2002*
'… I do not think enough weight has been given to the oral fungal infection which my wife suffered for seven weeks. Although technically … not "life threatening", it dragged her down and contributed to her decline. More strenuous efforts in the surgical

wards at the early stages could have made a big difference for the better.'

Letter *to the Trust (undated)*
'... a staff nurse in Ward 10 ... told my eldest daughter that the condition of [Mrs C's] mouth when she came up from Ward 5 "... was a disgrace. I have never seen a mouth as bad as that". The concentrated pattern of oral hygiene that was conducted was only started in Wards 9/10 with frequent application of Nystatin and hourly swabbing. Prior to that in Ward 5, it was less frequent Nystatin and no swabbing as far as I can remember. I used to apply the Nystatin sometimes because it was overdue.'

Points *in response to notes of a meeting held on 4 November 2001*
'Did [the catering company] ever inform nursing staff that [Mrs C] could not eat the food provided because she was a diabetic and that the promised "calorie rich ice cream and build up soups" were nowhere in evidence, save once in fourteen days? This amounts to 28 meals, of which 27 were not suitable.'

'I regarded the failure to feed my wife her prescribed diet to be a matter between the dietician, kitchen, servers and myself and not the ward staff and therefore did not feel the need to involve them. I was bringing food in to Ward 5, not as a treat but because my wife was being starved ...'.

Letter *to this office dated 13 May 2003*
'... my wife ... received neglectful treatment [at the hospital] during March and April [2002] which in my opinion materially reduced her survival chances after an operation ...'.

Letter to this office dated 27 May 2005
'[A] microbiologist and dermatologist attended because I asked for them not the nursing staff. I was told it would take a week but I refused to accept this.'

Trust's comments to this office

7. In comments to this office at the start of this investigation the Trust's Chief Executive said, as regards the complaint that there was an unreasonable delay in diagnosing Mrs C's cancer and that she had been referred to Consultant 1 in February 2001 with a history of iron deficiency anaemia. The Chief Executive continued:

> `The referral letter was vetted by [SHO 1] and she was considered to require a "soon" appointment. [Consultant 1] saw her at his clinic on 17 April 2001 and, as a result of his findings, she was placed on the waiting list for flexible sigmoidoscopy and barium enema. The barium enema was carried out on 22 June 2001 and showed diverticular disease in the sigmoid colon with faecal residue in the caecum which obscured mucosal detail. It was therefore arranged that [Mrs C] would have a colonoscopy which was carried out on 10 July 2001. Regrettably again there was poor visualisation of the colon due to faecal residue …
>
> [Mrs C] was admitted as an emergency to the Medical Unit under the care of [Consultant 2] … on 25 July 2001 with symptomatic anaemia and low haemoglobin. She was discharged on 27 July 2001 after a blood transfusion.
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> She was re-admitted on 2 October 2001 for a repeat gastroscopy and colonoscopy, with the latter being carried out that day by [SHO 2] … The examination showed no evidence of mucosal tumour, although there was mild diverticular disease in the sigmoid colon and possible terminal ileitis. The biopsies that were taken were later reported as colonic mucosa with no evidence of Crohn's disease.
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> Due to the failure to identify a gastrointestinal source of haemorrhage, [Consultant 1] referred [Mrs C] to the Haematologists on 16 October 2001. She was seen on 14 November 2001 by [Consultant 3] who suggested that the surgeons consider the possibility of an inflammatory bowel

disease, such as Crohn's disease. However, this was against a background of a negative biopsy of the terminal ileum.

In the meantime, [Mrs C] had developed post-menopausal bleeding and was referred by her GP to [Consultant 4] in mid October 2001. [Consultant 4] saw [Mrs C] on 22 November 2001 on an urgent basis. An ultrasound was carried out on 17 January 2002 which was essentially negative and her bleeding had stopped. [Consultant 1] was aware of this referral and had planned to review [Mrs C] following her gynaecological investigations. Unfortunately, due to an administrative failure, [Consultant 1] was not made aware of the outcome of the gynaecological investigations and [Mrs C] was re-admitted under the care of [Consultant 5] on 26 February 2002, some 5 weeks following [Mrs C]'s negative ultrasound.

The histology from the specimen taken during [Mrs C]'s surgery on 19 March 2002 showed that she had a moderately/poorly differentiated adenocarcinoma. Fourteen lymph nodes were examined and were free from tumour and there therefore was no evidence of distal metastases. The previous biopsy taken on 2 October 2001 showed no specific abnormality.

Had the cancer been present from June 2001 and had it been aggressive it would be expected that there would have been evidence of lymphatic spread on 19 March 2002.

In conclusion the total length of time elapsed from initial referral from [Mrs C]'s GP on 16 February 2001 until [Mrs C]'s emergency admission on 26 February 2002 under the care of [Consultant 5], was 54 weeks. During this time [Consultant 1] and his clinical team undertook a series of entirely appropriate investigations … It is unfortunate that during this specific period [Consultant 1] himself was on sick leave from 6 May 2001 until mid August 2001, ie 15 weeks. The Trust acknowledges that, had [Consultant 1] not been on sick leave, the timescale for these investigations may have been shortened. It should be

noted that [Mrs C] did not die from a spread of the tumour but from complications arising from the procedure undertaken. It is unclear the extent to which this 54 week period from initial referral contributed to the final outcome.'

8. As regards the complaint that Mrs C was not considered for admission to the High Dependency Unit in the early postoperative period the Chief Executive wrote:

> `At the time of her admission on 26 February 2002, [Mrs C] was frail and anaemic. Investigations revealed the possibility of a colonic tumour invading the area of the gall bladder or of an abscess from the gall bladder adhering to the colon itself. Her clinical condition deteriorated rapidly and [Consultant 5] … determined that surgery was the most appropriate way forward.
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> The surgery, which was carried out on 19 March 2002, was itself relatively uneventful. However, due to [Mrs C]'s general state and frailty, her progress was slow. The main difficulties were [Mrs C]'s generalised frailty and discomfort with loose bowel motions and diarrhoea, which often accompany this type of surgical intervention. She was reviewed at least twice daily following surgery, including review by [Consultant 6] on 21 March 2002, standard for all patients recovering from major surgery.
>
> [Mrs C] was noted to be well on 23 March 2002, although she required fluids to correct a drop in her urine output. An irregular pulse was noted on 25 March 2002. An ECG showed no evidence of atrial fibrillation and no acute change. In retrospect [Consultant 5] feels that it may have been appropriate to have considered [Mrs C] for admission to the High Dependency Unit at this point but the changes on her ECG were relatively minor and she responded to simple measures in the ward.
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> [Mrs C] was seen by [Consultant 7] on the ward round on 30 March 2002 and was noted to be well with no acute problems.

Later that day she had an episode of shortness of breath but no other symptoms of pain, cough or specific complaint and within two hours appeared much more settled. Here again, [Consultant 5] feels that, in retrospect, it may have been appropriate to have admitted [Mrs C] to the High Dependency Unit in view of her sudden symptoms of tachypnoea; however, again these settled in the ward with relatively simple treatment and within a short time.

On the ward round on 31 March 2002, [Mrs C] was seen by [Consultant 8] who also saw her on 2 April 2002 when she was noted to have been feeling better with all parameters stable.

Consideration was given to admission to the High Dependency Unit on 5 April 2002 in view of evidence of a pleural effusion on chest x-ray, although this did not take place. [Consultant 5] has acknowledged that management in a High Dependency Unit would have been preferable for [Mrs C] at this stage.

[Mrs C] was thereafter progressively seen by the Dermatology team and General Medical team and was carefully managed, carefully monitored and responded to the specific treatment episodes at every stage.'

9. In relation to the complaints that nursing staff failed to ensure Mrs C received adequate post-operative nutrition and mouth care and failed to manage her fluid balance optimally the Chief Executive wrote:

'Nutrition
It is not routine practice to record a patient's dietary intake within nursing records. There is regular reference to the need to encourage diet throughout the nursing notes, as well as reference to the dietician being contacted. In addition, nutritional supplements were issued in the form of high calorie drinks and oral medication. Naso-gastric feeding was commenced when [Mrs C] was too unwell to tolerate oral diet.

Since then, but not related to [Mrs C]'s complaint, Hairmyres Hospital has introduced a nutrition screening tool to identify any patients at risk of under-nutrition. In addition, a Hospital Nutrition Group has been established to ensure that NHS QIS Guidelines[2] are met .

It has been documented on one occasion in the nursing notes that [Mrs C] did not receive an appropriate diet and the dietician was contacted regarding this. The Trust accepts [Mr C]'s view that his wife did not always receive the diet ordered by the dietician. However, there are numerous references throughout the nursing notes to the fact that diet and oral fluids were encouraged. In addition, [Mrs C] was reviewed by both the Dietician and a Consultant Gastoenterologist, following which she was commenced on naso-gastric feeding to ensure an adequate nutritional status.

Fluid Balance

Fluid balances have been documented throughout [Mrs C]'s case notes in a regular and systematic manner. When any risk of dehydration was identified, intravenous fluids were initiated and once again these are referred to in the nursing notes. There is also reference throughout the nursing notes to encouragement having been given to [Mrs C] to sip oral fluids. As per comments on nutrition, it is of note that naso-gastric feeds were also commenced when [Mrs C] was unable to tolerate adequate amounts of diet or fluids orally.

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[2] NHS Quality Improvement Scotland guidelines on nutrition were first published in October 2002 and revised in September 2003 and set out 'Clinical Standards for Food, Fluid and Nutritional Care in Hospitals' which include sections on assessment, screening and care planning in relation to nutrition, when a person is admitted to hospital and the provision of nutrition directly to patients.

Mouth Care

There are numerous entries in [Mrs C]'s nursing notes relating to the administration of oral hygiene, although there are periods when this has not been documented. However, it is of note that [Mrs C]'s mouth condition was considered to have been so severe that she was prescribed various treatments for this, including anti-fungal treatment. When this did not improve, [Mrs C] was referred to both a Consultant Microbiologist and a Dermatologist. They ordered mouth swabs and initiated additional treatment for her extremely poor mouth condition and considered that, if there was no improvement, a biopsy should be undertaken. These referrals would also suggest that nursing staff demonstrated a clear commitment to care for [Mrs C]'s oral hygiene.

The Trust has assumed that mouth care was carried out in the periods when it was not documented at other times. However, there is considerable documentation to support the fact that care was given and that [Mrs C]'s mouth condition was so severe that the unusual steps of referral to a Dermatologist and Microbiologist were taken.'

10. Finally, in response to the complaint that nursing staff failed to arrange input into Mrs C's care by nursing specialists in diabetes or colorectal cancer the Chief Executive wrote:

`... At the time of her last admission to the hospital on 26 February 2002, [Mrs C] was a known diabetic. During this admission she attended the Diabetic Screening Clinic on 4 March 2002. The notes from this clinic indicated that [Mrs C] was coping very well and had no problems in the control of her diabetes. Throughout her admission regular monitoring of her blood sugar level was carried out and this has been documented. In addition, medical staff regularly reviewed [Mrs C] in this regard.

Diabetic nurse specialists work primarily in outpatient settings, offering educational support and advice on treatment and care. Their focus in relation to inpatients is mainly on educational intervention for newly diagnosed diabetic patients. This therefore did not apply to [Mrs C] who had longstanding diabetes.

Similarly, colorectal nurses focus on assisting with diagnosis, mainly on an outpatient basis. However, it is accepted that this particular nurse specialist would have been able to offer [Mrs C] – as a newly diagnosed patient – and her family, some additional advice and support in the ward.

However, it is inappropriate for all inpatients to be seen by specialist nurses, principally because ward nursing staff are competent in their care and to do otherwise would fragment the delivery of that care.'

Written evidence of Consultant 1

11. In preparation for the Trust's response to this office at the start of this investigation Consultant 1 wrote a report which included:

'I saw [Mrs C] personally at my clinic on 17 April 2001. She was a 70 year old lady, a maturity onset diabetic with a long history of constipation. She had no other GI [gastrointestinal] symptoms and had responded well to oral iron by her GP. The only other history of note was mild iliac fossa discomfort. Abdominal examination was unremarkable and she was put on our waiting list for flexible sigmoidoscopy and barium enema.

Following this I was on extended sick leave from 6 May 2001 to mid-August 2001 … During that time the patient underwent barium enema on 22.6.01 … Although the radiologist was of the opinion that it was probably clear, a minor mucosal abnormality could not be excluded and colonoscopy was recommended. In my absence under the auspices of [Consultant 8], the patient was listed for colonoscopy which she had on 10.7.01. Unfortunately as with the

barium enema there was much faecal residue and the colonoscopy was unsuccessful with poor visualisation of the colon due to poor bowel prep … On 25 July 2001 the patient was admitted with symptomatic anaemia … under the care of [Consultant 2]. Following transfusion of 4 units of blood she was discharged home for follow up by the Surgical Team as previously planned. She was re-admitted on 2 October 2001 for repeat gastroscopy and colonoscopy. … I myself was not back at work until mid August. I did not see the patient from April 2001 until she was re-admitted for repeat scopes in October 2001. Colonoscopy was carried out on 2 October 2001 by [SHO 2] … and the scope was reported as being passed to the terminal ileum with no evidence of mucosal tumour … The Endoscopists felt that they had identified the terminal ileum via ileo-caecal valve and had taken biopsies. These biopsies were later reported as colonic mucosa with no evidence of Crohn's Disease.

Because of our failure to identify a GI source of haemorrhage the patient was referred by myself on 16 October 2001 … to [Consultant 3] at the Haematology clinic. On 14.11.01 the patient was seen by [Consultant 3]. Clinical examination was unremarkable at that time but he felt because of the patient's negative scopes and elevated ESR that we should consider inflammatory bowel disease such as Crohn's disease. She did however at that time have negative biopsy of the terminal ileum.

… When I received [Consultant 3]'s letter about the patient on 15 November 2001, the patient had yet to be seen by [Consultant 4] at his clinic - this did not occur until 22 November 2001. We therefore wrote to the GP and advised him that at this time we would not arrange any further Surgical follow up until the outcome of [Consultant 4]'s investigations in light of her obvious per vaginal bleeding and lack of GI findings to account for anaemia.

… On 24 January 2002 [Consultant 4's SHO] wrote to the GP saying that because the patient had a negative scan and PV [per vagina] bleeding had stopped that they would not proceed to

hysteroscopy. The patient was apparently advised of this over the telephone and unfortunately I was not party to a copy of any of the correspondence between the Gynaecologists and the GP at this point.

Before the matter could be taken any further by myself, the patient was admitted as an emergency under the care of [Consultant 5] on 26 February 2002 ... Subsequently she had an ultrasound which showed … a mass in the right flank. This led on 28 February to a CT scan, which showed a mass in relationship to the ascending colon suggestive of malignancy.

… I am very sorry that Mrs C had a poor outcome from her treatment. I was largely uninvolved, apart from seeing her in April 2001 and arranging investigations. I was later only involved when she was in for the day for her gastroscopy and colonoscopy which proved negative and arranged appropriate follow up by the Haematologists with a view to seeing her again if her Gynaecological investigations (because of the post menopausal vaginal bleeding) failed to show a cause for her anaemia.

There was indeed a delay in diagnosing her right colon cancer but it was not for the want of trying. The patient had a gastroscopy and barium enema, followed by two colonoscopies prior to her admission in February 2002 but it wasn't until a CT scan showed the possibility of a tumour that a third colonoscopy eventually showed the tumour. The probabilities are that the tumour was either so small at the initial colonoscopy that it was obscured by the stated faecal contamination on both barium enema and colonoscopy, or that on her second colonoscopy the Endoscopists were mistaken in identifying the ileo-caecal valve as is shown by the fact that the biopsies which were thought to be terminal ileum, turned out in fact to be colonic. This would mean that they had failed to visualise the ileo-caecal valve and hence failed to visualise the tumour.'

Oral evidence of Consultant 1

12. Consultant 1 said that while he was off sick from 6 May 2001 to mid August 2001, Consultant 8 was responsible for his patients. On Consultant 1's return from sick leave Mrs C was in the file for a repeat colonoscopy with no indication of any urgency. Consultant 1 thought that the bowel was clear following the colonoscopy on 2 October 2001 because there was no evidence from the colonoscopy of a tumour although he acknowledged that the pathology showed that the biopsy had not been taken from the caecum but from another part of the bowel [meaning that the colonoscopy had not visualised the entire large bowel]. He accepted that he had been aware of the biopsy result which was evident from his letter to Consultant 9 dated 16 October 2001 which included '… biopsy showed this to be normal colonic mucosa.' He decided not to arrange a surgical review until the completion of the gynaecological investigations because it was not cost effective to have two teams investigating the same thing. The gynaecological investigations were concluded on 18 January 2002 but a surgical review was not arranged then because no-one told him that the gynaecological examinations had been completed. Consultant 1 said that although there was undoubtedly a delay in reaching the correct diagnosis, it was not unreasonable as every attempt had been made to investigate the problem. Also the delay did not influence the outcome as Mrs C succumbed from post-operative medical complications.

Oral evidence of Consultant 8

13. Consultant 8 took up post at the hospital on 1 July 2001 from when he was looking after most of Consultant 1's patients, including Mrs C. He moved to another post in the hospital when Consultant 1 returned to work in early to mid August. Consultant 8 said that following a colonoscopy that is not satisfactory, normally another colonoscopy or a barium enema is arranged. From the clinical notes, he could say that the bowel preparation for the colonoscopy on 10 July 2001 was poor and SHO 1, who performed the colonoscopy, wanted to bring Mrs C in to hospital for bowel preparation in four weeks. The notes would have been sent to nursing staff for an appointment to be made but in the meantime, 15 days later, on 25 July Mrs C was admitted by the physicians with an iron deficiency anaemia. She was

discharged home on 27 July. The physicians would normally write to the surgeons and ask them to proceed with their plan after the physicians' investigations were concluded. A letter dated 8 August from the physicians to Consultant 8 was sent with a copy of Mrs C's discharge summary including '.. no medical follow up has been arranged due to her ongoing investigations with Consultant 1.' Consultant 8 had no recollection of seeing that letter. If he had seen it, he would have brought Mrs C in within 4 weeks for a colonoscopy given her history, age and that there had been no explanation for her anaemia. Consultant 8 thought the picture became confused because of Mrs C's admission to the medical ward and Consultant 1's return to work. Consultant 8 also had no office and all of his correspondence was dealt with by Consultant 1's secretary which may have confused matters further.

Oral evidence of Staff Grade 1

14. Staff Grade 1 performed Mrs C's surgery on 19 March 2002. He said that it was a technically straight forward operation. After the operation Mrs C would have been returned to the same ward. He had no control over which ward she went to. The anaesthetist and Consultant 5 would have decided whether or not she required admission to HDU. Triggers for admission to HDU would have been evidence of leakage, temperature, tachycardia, and abdominal distension. Post-operatively Staff Grade 1 probably would have seen Mrs C in the ward soon after her operation to make sure she was alright but other than that he was not involved in her post-operative care.

Written evidence of Consultant 5

15. During the Trust's investigation of the complaint Consultant 5 wrote:

> 'This frail 71 year old lady was admitted initially to the hospital on 26/2/02 with unexplained anaemia and persisting right flank pain. Her haemoglobin at the time of admission was 7.4. She had evidence of liver dysfunction with an albumin of 30 and had an obvious hard mass in the right upper abdomen on clinical examination. Subsequent investigations indicated that she had chronic calculus cholelithiasis in addition to a small right lung

pleural effusion, perhaps related to her hypo-albuminaemia and mild heart failure, and also evidence of right sided colonic tumour. This was found to be a poorly differentiated adenocarcinoma. She had a laparotomy and right hemicolectomy with an ileo-transverse anastomosis on 19/3/02. The tumour at the time of surgery was found to be large, involved the caecum and ascending colon and was adherent to the lateral abdominal wall and to the duodenum. This was therefore a Duke's C2 tumour with an anticipated poor overall survival similar to that of a Duke's D classification.

Post-operatively Mrs [C] coped poorly with the recovery period. She appeared frail, fragile and had persistent problems with low grade diarrhoea, prolonged post-operative ileus (although the surgery itself appeared straightforward) and in particular had problems with right-sided pleural effusion, mild respiratory failure and cardiac failure. She was treated intensively for all these medical problems and suffered a sequential number of uncomfortable episodes. Her albumin was persistently low despite nutritional support and she developed a urinary tract infection with the resistant form of enterococcus faecalis which required Vancomycin as treatment. This proved particularly difficult for her.

She had repeated post-operative chest infections and associated problems with mild congestive failure, and this, coupled with her overall frailty and difficulty in eating, proved very difficult for Mr [C]. He was extremely attentive and lived with his wife in the hospital virtually night and day. She also developed the post-operative pulmonary embolus which was diagnosed and treated and was the reason for her move from Ward 5 to Ward 9. She did have some ECG changes post-operatively indicating that she may have had an ischaemic attack during the surgery. This, however, was really not a major contributory fact in her overall post-operative decline.

Mrs [C] was intensively managed surgically and medically throughout her stay in Ward 5 and I could not agree that the staff in Ward 5 were incompetent, uncaring or in any way lacking in

nursing skills. I would agree, however, entirely with Mr [C] that there were not enough nurses on shift and the level of care required by his wife was such that she really needed a one to one nursing approach for virtually the whole of her post-operative period. As you know I have repeatedly commented on the shift numbers in each of the Surgical Unit wards and this unfortunate lady's death and the subsequent comments made by her husband simply highlight the deficiencies in staffing in the Surgical Unit.

… I would also agree with him that the ward was inadequately cleaned and I think that his comments on dirt, debris etc are substantially correct …'

16. In a letter to this office Consultant 5 said:

'On 21.3.02 I discussed the question of admission to HDU with [Consultant 6] …

On 25.3.02 I note that on that occasion Mrs [C]'s pulse had become irregular and that her condition was closely monitored during that day. At that stage I did discuss admission with on-call staff for the HDU but I note also from my record that with appropriate treatment Mrs [C]'s condition improved to the point where her clinical situation would not have triggered a need for definite HDU admission. Although this was discussed with HDU staff at the time I regret that I have not recorded the name of the individual with whom this was discussed.

At 6.10pm on 5.4.02 chest x-ray showed evidence of pleural effusion and a specific request was made for admission to HDU at that point. She was given full management in the ward and I note that she was not admitted to HDU on that date. I note that on 6.4.02 according to my own records Mrs [C]'s condition remained stable but continued to cause concern. Admission to HDU on 5.4.02 was specifically discussed with the on-call staff that day and I presumed in my notes made at the time that the Unit was full.

Despite this, arrangements were made specifically to provide additional nursing care for Mrs [C] in the ward situation.

I note [during the Trust's investigation] regarding the care of Mrs [C] that I indicated that Mrs [C] required intensive medical support while she was on the Surgical Unit all of which she was given. She was carefully managed, carefully monitored, and responded to the specific treatment episodes at every stage. There were specific points during this period where I felt that she would probably have preferred management in a High Dependency Unit where staff could have given her the one on one care and psychological support which Mr [C] felt was essential for his wife's care.

Given that the Acute Surgical Unit Nursing Staff out of necessity have to prioritise their time, the type of care which Mr [C] expected could really only be provided by continuous High Dependency Nursing. According to the protocols then in use this was not considered appropriate by the Consultant Anaesthetic, Consultant Medical and Surgical Staff who were caring for her in the post-operative period.

… To the best of their ability the Trust responded by additional nursing input on an ad hoc basis where and when required. … I am able to assure you that Mrs [C] received the full extent of care which was capable of being provided by the NHS in Hairmyres at that time.'

Oral evidence of nursing staff

17. The Sisters in charge of Wards 2, 5 and 10 and a total of eight staff nurses from Wards 2, 5, 9 and 10 were interviewed by my Investigating Officer and the 2nd Assessor. Their evidence is referred to in the 2nd Assessor's report.

Oral evidence of the Associate Director of Nursing (ADNS)

18. The ADNS took up her post in December 2001. She has overall responsibility for nursing within the hospital. She said that she found it

difficult to find a connection between the care planning and the documentation contained within Mrs C's nursing notes in this case. Having looked through the nursing notes, she had concerns about the care planning. There was not always documented evidence that the appropriate care was given. She noted that fluid balance charts were not completed properly. A dermatologist had been called to consider Mrs C's mouth condition and although the nursing notes did not provide evidence that regular oral hygiene had been provided for Mrs C, the ADNS believed, having spoken to staff, that they gave high focus to mouth care. She felt that nursing staff had in the documentation focused more on critical analysis, for instance, oxygen saturation. She believed that oral hygiene was carried out and staff assured her that attention had been given to Mrs C's nutrition and fluid balance but she conceded that she could not always see the evidence for that in the notes. The ADNS confirmed that there was some evidence that the appropriate diet did not always arrive. She said that at the time when the complaint was made she did not know staff very well, however, she knows staff now and in her view they are honest and work to high standards.

19. The ADNS said that care planning should be consistent across the hospital, with some differences for CCU and HDU and to that end, a senior nurse had been seconded onto a group to consider care planning, to allow them to have a more uniform approach. Care planning was still an issue because the care plans are different in areas which can cause difficulty with continuity of care. The working group was currently looking at care planning across the whole area and at best practice. Until the group completed its review, an interim care plan would be introduced so that all wards were using the same care plan.

20. At interview with the Ombudsman's officer, the ADNS advised that complaints had dropped significantly because they now intervened very early and had introduced a number of measures to improve services in the hospital. They now use a scoring system to alert staff to the fact that a patient's condition is deteriorating and nurses write the report at the bedside so that they are using not only the information in the notes but also observing the patient while they do that. Two senior nurses had been appointed, one for medical and accident and emergency, and

the other for surgical. These nurses have a visible presence on the wards and the main function of their job is to provide clinical leadership and support.

21. The ADNS said they now also have a hospital emergency care team, comprising highly skilled nursing staff working with doctors, and if there is any concern on the MEWS scores (Modified Early Warning Scoring System), the hospital emergency care team will be called. She explained that the score triggers are used to determine whether or not the patient needs any intervention or ITU/HDU care and the Emergency Care Team would then assess and determine that. They had also introduced a new drug recording sheet and also, as a result of this complaint, a new nutrition screening tool and fluid balance sheet. They had also introduced a handover sheet to alert management to any issues of concern on the ward or department such as changes in staffing levels and the ADNS had regular meetings with ward managers and senior nurses. However, the key element of change was the review of care planning.

22. The ADNS said as far as cleanliness of wards was concerned, the hospital had been identified by Audit Scotland, around the time of Mrs C's admission, as being in category 4 which was the lowest category[3]. As a result, the Trust convened a hospital hygiene committee and about a year later the hospital was judged as being in category 2 which was the second highest[4].

Assessors' reports

23. I reproduce next, in its entirety, the report prepared by the 1st Professional Assessor, a Consultant General and Colorectal Surgeon, who was appointed to give advice on the complaint.

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[3] Category 4 is defined in Audit Scotland's report *Hospital Cleaning* (January 2003) as 'where at least one ward or public area is classified as being of concern or all wards/public areas show a need for improvement'.

[4] Category 2 is defined in Audit Scotland's report as 'wards mostly very good or acceptable with one need for improvement'.

Matters considered

(i) Whether there was an unreasonable delay in diagnosing Mrs C's cancer and whether admission to the High Dependency Unit in the early post-operative period would have improved post-operative management.

Basis of the report

(ii) The patient's medical and nursing records have been reviewed and interviews conducted with relevant members of medical staff.

Comments on the actions of medical staff

(iii) On 17 April 2001, Mrs C was seen by Consultant 1, after referral by her GP for investigation of iron deficiency anaemia. Her name was placed on the waiting list for flexible sigmoidoscopy and a barium enema.

(iv) On 22 June 2001, the barium enema showed a condition known as diverticular disease. However, the caecum and ascending colon were not adequately visualised and colonoscopy was arranged. Around this time, Consultant 1 was on sick leave until mid-August and his duties were undertaken by Consultant 8, a locum Consultant Surgeon.

(v) On 10 July 2001, a colonoscopy was attempted by SHO 1. The procedure was abandoned because of poor visualisation due to faecal contamination. It is recorded that a repeat colonoscopy and gastroscopy be arranged in four week's time.

(vi) On 25 July 2001, Mrs C was admitted under the care of Consultant 2 with symptomatic anaemia. She was transfused four units of blood and discharged, a copy of the discharge summary going to Consultant 8 stating that investigations were ongoing under Consultant 1's care. This clinical finding would have raised a strong possibility of a tumour in the stomach or large bowel as a possible cause of the anaemia. Neither Consultant 8 nor Consultant 1 recollects seeing this letter. Both state that they

would have expedited the repeat colonoscopy had they been aware of the recent admission.

(vii) *On 2 October 2001, Mrs C was readmitted for colonoscopy and gastroscopy. The gastroscopy was carried out by SHO 2 with Staff Grade 1 in attendance. This showed no evidence of a tumour in the stomach. The colonoscopy was carried out by SHO 2 unsupervised. It is recorded that the whole large bowel was visualised and the terminal ileum biopsied. This would have given absolute confirmation that the colonoscopy was complete. The biopsy showed normal large bowel tissue and it could not be concluded that the entire large bowel had been visualised.*

(viii) *On 16 October 2001, Consultant 1 referred Mrs C to the haematologists as she remained significantly anaemic.*

(ix) *On 14 November 2001, Mrs C was seen by Consultant 3. Her blood count had fallen further at that time. Specimens of stool showed the presence of blood and the opinion was that Mrs C's blood loss was undoubtedly from the gastrointestinal tract.*

(x) *Mrs C had been referred by her General Practitioner on 15 October 2001 with vaginal bleeding. Consultant 1 was aware of this referral on receipt of Consultant 3's letter and felt that further investigation of the gastrointestinal tract was not indicated until the gynaecological investigations were completed.*

(xi) *On 19 November 2001, Mrs C was seen by SHO 3 (Gynaecology). The history was of very scanty blood spotting and no abnormality was found. An ultrasound scan was organised and carried out on 17 January 2002. No abnormality was found and Mrs C was informed by telephone that no further action was required. No copy of this information was sent to Consultant 1 but it is unclear whether the gynaecologists were aware that Mrs C was undergoing investigations under Consultant 1's care.*

(xii) *On 26 February 2002, Mrs C was admitted as an emergency under the care of Consultant 5. She was again significantly anaemic and a scan confirmed an abdominal mass. A further colonoscopy carried out on 13 March 2002 by Staff Grade 1 confirmed a large tumour in the right side of the large bowel.*

(xiii) *On 19 March 2002, Staff Grade 1 performed surgery to remove the bowel tumour. Initial progress was satisfactory but there were a number of ongoing clinical problems from the third post-operative day throughout the remainder of her admission.*

(xiv) *On 21 March 2002, and again on 25 March 2002, consideration was given to admission to the High Dependency Unit but appropriate action on the ward seemed to stabilise the situation.*

(xv) *On 5 April 2002, Mrs C's condition again caused sufficient concern that High Dependency admission would be appropriate. It is not clear why this did not take place. Over the next few weeks Mrs C was treated in both surgical and medical wards until her death on 7 May 2002. There are specific triggers for admission to High Dependency Units based on various physiological disturbances (abnormal measurements of pulse, blood pressure, urine output, oxygen levels, etc). It is not clear from the records whether failure to admit to High Dependency was as a result of lack of available beds or other reasons.*

Comments

(xvi) *The diagnosis of right-sided large bowel tumours can be very challenging. Accurate assessment, whether by colonoscopy or barium enema, depends on adequate preparation to clear the bowel of faecal matter and it is not unusual for either or both of these investigative methods to be unsuccessful. If there is a clinical suspicion of tumour, and one of the commonest presentations is recurring iron-deficiency anaemia, these examinations may have to be repeated on a number of occasions. Alternatively, a different approach such as CT colonography would be indicated.*

(xvii) *There are a number of issues which led to a delay in diagnosis in this case. The initial barium enema and colonoscopy were unsuccessful because of inadequate bowel preparation. At the time when arrangements were made to repeat the colonoscopy, the Consultant in charge (Consultant 1) was on sick leave and the locum Consultant (Consultant 8) was not informed of the patient being admitted to a medical ward with a significant anaemia which required transfusion. This appears to be a system failure as the information was sent but did not come to the attention of either Consultant 8 or Consultant 1, who returned to work soon afterwards. This resulted in a delay of ten weeks for a repeat procedure which was originally scheduled within four weeks.*

(xviii) *The second colonoscopy also led to further confusion in that it was reported as normal and stated that the examination had been complete. There is a failure in completion of colonoscopy (reaching the region where the small bowel joins the large bowel) which varies between endoscopists but on average is around 10% of procedures. One failsafe way to prove completion is to biopsy the small bowel and this was recorded as having been done. When the biopsy report showed normal large bowel, that should have alerted the clinicians involved that the procedure could not have been regarded as being complete. In the presence of recurring anaemia and the presence of blood in the stool, colonoscopy or barium enema should have been repeated or consideration given to CT colonography.*

(xix) *Further significant delay occurred because of gynaecological investigations. There again appears to be a system failure, as Consultant 1 delayed further investigation until the result of the gynaecological studies were known and there was no communication between these two disciplines.*

(xx) *Consideration was given to High Dependency admission in the early post-operative period. It is not possible to ascertain the reason why this did not take place. One of the commonest*

reasons is lack of available beds but there is not documentation to substantiate whether this was the case. The various episodes of post-operative problems which might have precipitated admission were stabilised on the ward and it is not possible to speculate whether High Dependency, with a higher nurse:patient ratio might have improved management. The numerous complications which Mrs C suffered are all recognised potential problems after this type of major surgery.

Conclusion

(xxi) *There was an unreasonable delay in diagnosing Mrs C's cancer. There are recognised factors which contributed to this. Notwithstanding the inherent difficulties in substantiating a diagnosis of right-sided bowel tumours, significant delays occurred because of system failures in communication and as a result of misinterpretation of a colonoscopy report. Some of these were perhaps unavoidable, particularly the changeover period between Consultant 1 and Consultant 8 which occurred at a crucial time in the investigative period. A trigger which would have allowed a repeat colonoscopy as a matter of urgency was missed.*

(xxii) *There was an assumption that the second colonoscopy was complete and showed no abnormality but the biopsy confirmed that this conclusion was not justified. Further attempts should have been made to visualise the whole of the large bowel at that stage. Subsequent referral to the Haematologists again highlighted recurring anaemia and blood in the stool, which should have raised the suspicion of a lesion in the gastrointestinal tract and the need for further investigation.*

(xxiii) *It is unreasonable to state that consideration was not given to admission to the High Dependency Unit in the early post-operative period. On three occasions this was considered because of various post-operative problems. It cannot be established from the records whether admission did not take place because of a lack of available beds or for another reason. It would not be*

reasonable to speculate that High Dependency care would have prevented subsequent complications nor led to their earlier diagnosis.

24. I reproduce, in its entirety, the report of the 2nd Professional Assessor, a Senior Nurse.

Basis of the Report

(i) *This report is compiled from information gathered scrutinizing complaint correspondence, the clinical records of the patient and interviews with nursing staff at the Trust where the patient received her care.*

Background

(ii) *Mrs C, was a frail 70 year-old woman who was admitted to the hospital, on 26 February 2002 for investigation of unexplained anaemia and abdominal pain. Mrs C had a history of being a non-insulin dependent diabetic; she suffered from a hiatus hernia and hypertension.*

(iii) *Investigation by colonoscopy on 13 March 2002 showed the presence of a fungating tumour on the right side of the bowel and on 19 March 2002 she had surgery to remove the tumour. Although the surgery was considered successful, Mrs C's post-operative period was difficult when she appeared frail and fragile and she presented with a combination of complications. In spite of active treatment she failed to recover and sadly died on 7 May 2002.*

(iv) *During her stay in hospital Mrs C was nursed on four different wards. Following surgery she was initially nursed on Ward 2 a surgical ward but she was transferred to Ward 5 another surgical ward as Ward 2 was closing. On 19 April 2002 her care was taken over by the physicians and she was transferred again to Ward 9, a medical ward. Due to 'bed problems' Mrs C was moved yet again on 25 April 2002 to Ward 10.*

(v) *For ease of reference the following is a table of dates when Mrs C was in each of the wards. Question marks appear at the 19 April 2002, as there is no record about the transfer from Ward 5 to Ward 9 but the ward number on the notes changes on that day.*

Ward	*Dates*
3	*26/2/02 – 28/2/02*
2	*28/2/02 – 28/3/02*
5	*28/3/02 - ?19/4/02*
9	*?19/4/02 – 25/4/02*
10	*25/4/02 – 7/5/02*

Matters subject to investigation

(vi) *Of the matters subject to investigation this report will consider the post-operative nursing issues relating to the following:*

- *That Mrs C was not considered for admission to the High Dependency Unit (HDU) in the early post-operative period*
- *That nursing staff failed to ensure she was provided with adequate post-operative nutrition and adequate mouth care and failed to manage her fluid balance optimally and*
- *Failed to arrange input into Mrs C's care by nursing specialists in diabetes and colorectal cancer.*

Consideration for admission to HDU

(vii) *Following surgery on 19 March 2002 Mrs C was initially nursed on Ward 2, a short stay surgical ward normally closed at weekends. It was a very busy high turnover ward dealing with pre and-post-operative elective surgical patients.*

(viii) *From approximately the third post-operative day Mrs C developed a number of complications. She was a frail and very sick woman. The staff of Ward 2 (Sister 1, Staff Nurse 1 and Staff Nurse 2) when interviewed were of the opinion that on any given day during her stay in the ward Mrs C did not warrant an HDU bed and she was being cared for appropriately in Ward 2. In*

retrospect Sister 1 felt that with her accumulative issues she would have possibly benefited from HDU care.

(ix) *At the time of Mrs C's admission the hospital did not have a critical care outreach system. This is a system whereby patients are scored against a set of criteria that determines whether there is a need to admit the patient to a HDU or an ITU, or whether extra resources or expertise could help in the ward situation.*

(x) *On a number of occasions Consultant 5 discussed the possibility of Mrs C being admitted to a HDU bed. She was not admitted and the reasons are not clear.*

(xi) *Nursing staff on the other wards in which Mrs C was a patient were of mixed opinion about whether she should have been in HDU. Some staff thought it would have been more appropriate, whilst others thought the wards were the right place for her to be. There is a medical note on 9 April 2002 about the possibility of HDU being considered.*

(xii) *The Trust now have a 'Modified Early Warning Scoring System' (MEWS) and this system triggers whether or not a patient is being cared for in an appropriate setting or a transfer to a higher dependency area would be more appropriate.*

Comments

(xiii) *Given the post-operative complications from which Mrs C was suffering, which on their own were manageable, together they created a situation compromising the condition of a very sick woman. Had a MEWS system been in place at the time Mrs C would in all likelihood have been assessed under that system with a view to HDU admission. Despite this, Consultant 5 gave consideration to this option on 21 and 25 March 2002 whilst she was in Ward 2 and on 5 April 2002 in Ward 5. It is not clear from the records why this did not take place although it is not uncommon for a lack of beds to be the reason.*

(xiv) *It is always a matter of clinical judgement based on the presenting symptoms of the patient whether it would be more appropriate for them to be receiving care in a higher dependency area. Sister 1 thinks with hindsight it would have been appropriate for Mrs C to be in a HDU. Staff from other wards later in her admission were of mixed view.*

Nutrition, mouth care and fluid balance

Overview

(xv) *There are two sets of nursing care plans the first relates to the care in Wards 2, 3 and 5.*

(xvi) *The plan assesses the activities of daily living for the period 27 February to 18 April 2002. Unfortunately the plan has not been followed in the way intended and is merely an extension of the daily progress records in another format. It gives no indication about a plan for nutrition, mouth care or fluid balance.*

(xvii) *Careful control of a patient's correct fluid balance is a key component to maintaining the essential body systems including the functions of the heart and kidneys and retaining the correct balance of chemical elements in the blood. Accurate monitoring of fluid intake and urinary output is particularly important in frail patients or in the early post-operative period as a means of preventing or providing early warning of heart or kidney failure. Fluid balance charts are used to record all fluid intake including drinks, nasogastric feeds and intravenous infusions for each 24 hour period. Urinary output is also recorded for the same period. Nurses should then calculate the 'balance' by subtracting the total output from the total input. They should bring to the attention of medical staff any difficulties in achieving an expected fluid intake; a low, or considerably reduced urinary output, or any excessive positive or negative balance.*

(xviii) *The other care plan, marked Ward 9, is in the form of core care plans and identifies actual or potential problems of the patient. There is no reference within this plan to problems associated with*

nutrition or a sore mouth. There are problem charts for intravenous infusions (IV) and indwelling urinary catheters. The plan appears to have been active for one day only. It is dated 24 April 2002 some five days after she was admitted to the ward and one day before she was transferred to Ward 10. It was evaluated once on the same day.

Ward 2

(xix) *Ward 2 is where Mrs C was a patient for her immediate post-operative period. Due to the nature of the surgery Mrs C had, her bowel would have needed to be 'rested' until such time as it was clinically safe to start diet. To maintain adequate hydration she had an IV/s in situ. It is difficult to determine from the conflicting charts whether this was one or two. Through this/these she was receiving, potassium, glucose and Actrapid insulin (referred to as GKI). Her urine volumes were being measured hourly. Insulin was calculated on a sliding scale according to her blood glucose measurement.*

(xx) *Throughout her stay in Ward 2 Mrs C continued to have intravenous fluids and her fluid balance was monitored. On a number of occasions it is reported her fluid intake was in a positive balance with urine volumes decreasing to a point where her output is recorded as poor. Medical staff were alerted and to try to resolve this her IV intake was increased. On 24 March 2002 she had a fluid challenge when her IV intake was increased significantly. After this Mrs C's intake still remained in a positive balance with output volumes varying. Throughout, her fluid balance charts are in the main conscientiously completed and constant reference to her fluid balance situation is recorded in her notes. It is noted she was prescribed oral and/or intravenous Frusemide (a diuretic). Her electrolytes were monitored regularly.*

(xxi) *There is no plan to determine how Mrs C's oral intake was being managed after surgery. Her notes record that at times she was tolerating sips of water although there is no indication of how often or the amount. On 22 March 2002 her fluid balance chart*

records she had 200 millilitres (mls) of tea on two occasions and the next day she had 100mls of juice. After that her oral fluid intake is spasmodically reported as sips or no oral intake. When interviewed the staff (Sister 1, Staff Nurse 1 and Staff Nurse 2) were of the opinion that Mrs C was not becoming overloaded with fluid and she was not oedematous or breathless. Had there been concerns they would have noted them.

(xxii) *On 23 March 2002 there is the first note that she was complaining of a sore mouth. The daily notes make mention from time to time that mouth care was given but not what this consisted of other than prescribed Nystatin and Diflucan, both oral preparations for fungal infections. The assessment of care highlights that Mrs C has mouth ulcers and the aim is to promote healing and aid comfort. There is no plan for how that should happen. The staff, when interviewed, said the plan would normally be to clean the mouth with sodium bicarbonate and apply Vaseline to the lips. They recognised their notes did not support the care being given.*

(xxiii) *On 26 March 2002 there is a record to say Mrs C had taken some diet although it does not say what. This is the only reference to her taking any diet on this ward.*

(xxiv) *There are entries in Mrs C's notes from 27 March 2002 that she was passing very loose stools and occasionally incontinent of faecal fluid. A chart to record and monitor her bowel movements was started on 28 March 2002.*

(xxv) *Mrs C's diabetes was managed by regular blood glucose monitoring and an appropriate sliding scale insulin regime. Medical staff were alerted if adjustments to this were required.*

(xxvi) *Throughout the period of care in Ward 2 Mrs C is regularly reported as being very tired or lethargic.*

Ward 5

(xxvii) *Mrs C transferred to Ward 5 on 28 March 2002.*

(xxviii) *In the first few days on this ward Mrs C was taking small amounts of diet and a referral to the dietician was made with a view to a high protein diet. She remained on IV fluids. Her bowel movements were noted to be very loose and on occasions she was incontinent of faecal fluids.*

(xxix) *At interview Sister 2 told us food is provided to patients by a hostess service and she was not sure whether, at that time, the ward had a dedicated hostess or different ones each day. The nursing staff told the hostesses which patients required special diets. At interview Staff Nurse 3 seemed very confused about Mrs C's dietary needs.*

(xxx) *It is reported that Mrs C's mouth was assessed as sore and should be observed. Staff at interview (Staff Nurse 3 and Staff Nurse 4) said they would not normally record routine mouth care and it would be done as a matter of course when they were attending to Mrs C's other needs. Sister 2 told us that because Mrs C had a sore mouth she would require a soft diet.*

(xxxi) *In terms of fluid balance, Sister 2 said that she could see that the charts had not always been filled in. She assumed this was because the ward was particularly busy. She said auxiliary nurses went round after meals ensuring relevant information was charted. Sister 2 could not recall any indication of fluid overload in Mrs C but did note that she was on occasions in positive balance. She thought some of this might be due to the fact Mrs C had diarrhoea and output could not be measured accurately. She did say Mrs C had oedematous legs but put this down to low albumin. Sister 2 would have expected the nursing staff to draw to the attention of the medical staff any marked difference in intake and output.*

(xxxii) *On 30 March 2002 there are the first reports that Mrs C is breathless and she has oedema of the sacrum and legs. It is reported she has a sacral sore and dressings were applied.*

(xxxiii) *On 31 March 2002 there were decreased bowel sounds and the doctor advised she had fluids only.*

(xxxiv) *On 1 April 2002 light diet was commenced. It is reported she is voiding good volumes of urine. Her bowels continue to be frequent and loose.*

(xxxv) *On 2 April she is again nil by mouth although the reason is unclear. Mrs C says she is feeling better. Oral fluids recommenced in the evening. Lower limb oedema worsening.*

(xxxvi) *On 3 April 2002 there is the first assessment of her skin integrity, which shows she is at very high risk and a special bed and mattress are used. Consideration about the possibility of anal plugs due to the persistent leaking of faecal fluid is also noted. It is now noted she can have diet and fluids.*

(xxxvii) *On 4 April 2002 there is the first note of pressure area care being carried out. Another note about referral to a dietician is made. The dietician visited later that day. It is reported no meal was sent from the kitchen for Mrs C although the staff report a small amount of diet was taken.*

(xxxviii) *On 5 April 2002 Mrs C had a blood transfusion after which she was prescribed Nutriflex feed, a parenteral (feed administered outside the alimentary canal) nutrition supplement. Mrs C continued to have IV Frusemide and potassium tablets. It is noted at 16.00 hours that there is a question about whether there is a need for a HDU bed.*

(xxxix) *On 5 April 2002 increases in the anti-fungal preparations for Mrs C's mouth are prescribed and swabs from her mouth obtained.*

(xl) *At 18.00 hours on 5 April the staff start recording Mrs C's observations on an hourly basis with an instruction to observe for*

heart failure. It is reported Mrs C was managing Enlive drinks (a food supplement). Her urine output was now recorded as excellent, unfortunately there is no fluid balance chart for that day to cross check the urine volumes. Fluid balance charts on other days have either been conscientiously filled in or range from not filled in at all to token gestures. Urea and electrolytes continue to be monitored with medication given and/or adjusted according to the results. Particular concern is reported regarding the low potassium levels.

(xli) *Early on 6 April 2002 the nursing staff report Mrs C's chest sounds more congested. The doctor was contacted and oxygen therapy was started, nebulised Ventolin, (a bronchodilator), Frusemide, and a chest X-ray ordered. Later that morning Mrs C had settled with reports that her chest was clearer.*

(xlii) *Medical staff continued to review Mrs C on a regular basis with medications adjusted as required.*

(xliii) *The dietician reported on 7 April 2002 she has organised for appropriate meals for Mrs C from the kitchen. She prescribes 2-3 Enlive drinks per day.*

(xliv) *The Dermatologist saw Mrs C and took swabs from her mouth and prescribed different medications.*

(xlv) *Later that day (7 April) Mrs C was reviewed by a Junior House Officer who thought Mrs C may have Chronic Obstructive Pulmonary Disease due to a fluid overload.*

(xlvi) *On 9 April 2002 the dietician was requested to review Mrs C again after a Physician saw her and recommended nasogastric (NG) feeding. The dietician started a special enteral (feeding into the alimentary canal) feed regime and charts record and monitor this for the period 9 April to 3 May 2002.*

(xlvii) *On 10 April 2002 Mrs C became distressed with her breathing. Her chest is reported as being very moist with a possibility she was aspirating. Her blood glucose was very high and the medical staff were informed.*

(xlviii) *The next night Mrs C had diarrhoea and her NG feed was stopped because of this. Her husband phoned the ward and was told of her condition, but this condition is not explicit within the notes. A discussion took place about calling the priest.*

(xlix) *On 16 April 2002 it is reported that the diet being sent from the kitchen for Mrs C is not suitable. Later that day it is reported Mrs C's mouth is slightly improved and she is taking a diet of soup and ice cream. At 23.00 hours Mrs C's blood glucose is reported as being off the scale and the medical staff made aware. Mrs C's fluid intake was now in a negative balance compared with her output.*

(l) *On 17 April 2002 it is noted the dietician spoke to Mr C regarding problems with meals supplied by the kitchen.*

(li) *Mrs C continued to be reviewed regularly by the medical staff with a recommendation that the Cardiologist review her.*

Ward 9

(lii) *There is no transfer record but it would appear Mrs C moved to Ward 9 on 19 April 2002. Staff Nurse 5 thought she had been transferred to this ward because she was in heart failure and possible renal failure. Mrs C was in a side room on this ward.*

(liii) *Mrs C continued to receive general nursing care for all of the problems she had on the other wards. We were told this is a medical receiving ward and patients do not normally stay longer than 24 hours and care plans are not used, unless for some reason a patient stays longer. Mrs C did stay longer but there is no specific plan about her care. The daily nursing notes are comprehensive.*

(liv) *Mrs C's condition continued to be medically poor. The nursing staff were regularly turning her to prevent further skin breakdown. She continued to be incontinent of faeces.*

(lv) *There are infrequent notes she had mouth care which Staff Nurse 6 told us would be done as routine for all patients unable to clean their own teeth. Staff Nurse 5 told us Mrs C's mouth was in quite a poor condition and they were providing a lot of oral care. She would always record care had been given but not necessarily what that care was.*

(lvi) *Urine volumes began to decrease again. Fluid balance charts were continued although the amounts were infrequently totalled. Staff Nurse 6 told us she thought the charts were inaccurate on one day as she thought someone had failed to record the contents of Mrs C's catheter bag. She also recalled sometimes when infusion bags were changed a patient did not always get a full bag infused which could alter the amounts. She said the same went for GKI bags. Staff Nurse 6 did recognise that if the results as charted were accurate it did suggest there may be fluid overload and she would have reported this to the medical staff.*

(lvii) *Staff Nurse 5 said at interview the fluid balance charts were not well totalled; she agreed there was a positive intake balance, which could have indicated fluid overload. She told us she would not have alerted the medical staff if the balance difference was only 500mls.*

(lviii) *There is a note that on 19 April Mrs C was referred to a Speech and Language Therapist although the reason for this is not documented. At interview Staff Nurse 6 told us it was to assess Mrs C's swallow as she had said she was feeling better and wanted to eat. There is no other indication to suggest Mrs C was having difficulty swallowing. The medical notes suggest the consideration of a percutaneous endoscopic gastrostomy (PEG) for feeding purposes. Staff Nurse 5 told us she was not involved*

in the provision of food for Mrs C as she was nil by mouth having NG feeding and a PEG was being considered.

(lix) *Later that evening, the family asked to speak to the doctor who advised they would not be inserting a PEG immediately and he told them Mrs C would not starve to death. A medical opinion the next day was Mrs C was not medically fit for PEG insertion.*

(lx) *Medical staff continued to review Mrs C over the next few days and on 21 April a doctor had a long discussion with Mr C. He was told they were obliged to treat the treatable and reversible biochemical deficits. He also told Mr C a pulmonary embolus may have been a critical event in causing Mrs C's deterioration although there was no confirmation of this diagnosis. There was an agreement to continue with therapeutic treatment. The doctor told Mr C the main concern was a good quality of life.*

(lxi) *On 22 April 2002 Mrs C is reported as much improved and a medical plan is recorded. A NG tube was re-inserted and feeding recommenced.*

(lxii) *Over the next few days Mrs C's condition fluctuated and the nursing and medical notes have entries throughout the day and night showing how attentive they were to Mrs C's medical and nursing needs. Mrs C's family were staying with Mrs C on a more frequent basis.*

(lxiii) *On 25 April 2002 Mrs C was transferred to Ward 10.*

Ward 10

(lxiv) *It is thought Mrs C was transferred to this ward because there was a shortage of beds. The transfer took place at approximately 12.30 am.*

(lxv) *All Mrs C's treatment continued as on other wards with comprehensive daily notes from the nursing staff, although again there is no care plan. Sister 3 who was in charge of Ward 10 told*

us they used care plans, which she thought were good. There are none evident for Mrs C. Staff Nurse 7 told us that the ward always used care plans, which were conscientiously completed. She was not able to find those for Mrs C.

(lxvi) *Mrs C continued to be fed via the NG tube. The nursing staff cannot remember Mrs C having any form of diet. Her stools were charted and monitored regularly.*

(lxvii) *The attention to detail regarding the fluid balance charts on this ward was not good and Sister 3 told us she thought the charts did not appear to be well marked up and NG feed was not always recorded. Sister 3 noted the positive intake and reflected this was perhaps due to catheter bags being emptied and not charted. We were told the charts had now changed and were more detailed.*

(lxviii) *Staff Nurse 7 said she thought the fluid balance had not been filled in correctly with omissions and staff not marking them up when bags had been emptied. She said if what was there was accurate it could suggest Mrs C had a renal problem or she was dehydrated and had it been a significant problem she would have told the medical staff but she could not remember the detail due to the passage of time.*

(lxix) *Oral hygiene was given as Mrs C could tolerate. Sister 3 told us she had no recollection of the state of Mrs C's mouth. Staff Nurse 7 said she provided mouth care for Mrs C as she has noted this in the records. She has not noted the condition of the mouth.*

(lxx) *Unfortunately Mrs C's condition deteriorated further and the resuscitation status was discussed with the family and it was agreed Mrs C would not be for resuscitation. Sadly Mrs C died on 7 May 2002.*

Comment

(lxxi) *It is clear from the notes that Mrs C was extremely weak following surgery and she had a number of significant and complex medical and nursing problems.*

Care Planning

(lxxii) *Effective care planning is an integral part of nursing. In Mrs C's case there is no overall comprehensive plan of nursing care based on her problems, potential problems or symptoms. Many of Mrs C's problems or potential problems were not assessed or reported. The correlation of Mrs C's care across the wards was extremely difficult and I found her nursing notes particularly difficult to navigate. There are numerous charts for various aspects of care but I am not sure I understand how these were used in influencing Mrs C's care.*

(lxxiii) *It is reassuring from interviewing the ADNS that she recognised and was critical of the care planning process and the inconsistency across the Trust. She was aware from looking at Mrs C's notes that care given was not always documented. She recognised it was still an issue and as a result a senior nurse from the Trust has been seconded to a group looking at care planning across Lanarkshire. This will not be ready in the foreseeable future but an interim care plan will be introduced.*

Fluid Balance

(lxxiv) *Fluid balance has been undertaken on all of the wards but it is meaningless as an exercise if the results are not used to influence decisions about treatment. Some wards attempted this better than others and some staff were obviously showing concern about urine volumes as treatment to resolve the situation was taken. My overall opinion from interviews with the nursing staff is that some recognised the significance of the results. Others did not appear to understand the importance of accurate fluid balance monitoring in recognising the potential problems or how they could be used as an aid to overall treatment management.*

Excuses were given for why the charts were not completed accurately.

Nutrition

(lxxv) *I find it difficult to follow the pattern of how Mrs C was assessed in respect of her nutritional needs and can best describe it as a muddle especially on Ward 5. From day to day in early April 2002 there are different notes about Mrs C being nil by mouth, to fluid only, to light diet and back to nil by mouth with no understanding of how these decisions were made.*

(lxxvi) *It appears that some nursing staff, especially on Ward 5, do not seem to recognise their responsibility for patient nutrition, a vital aspect of care. The hostess service seems to take responsibility for the provision of meals on wards with little or no input from the nursing staff.*

(lxxvii) *The dietician was involved on a number of occasions and she ordered diet for Mrs C but the kitchen staff were sometimes not sending these to the ward. Mr C was concerned to a point where he suggested he would buy ice cream himself. The dietician also calculated the enteral feeding regime, which changed from time to time as it was thought this was contributing to Mrs C's diarrhoea.*

(lxxviii) *There was mention that they were considering a PEG for feeding purposes but not why. Nursing staff recorded from time to time diet and fluids were being tolerated. Medical staff note on one or two occasions that Mrs C was malnourished.*

(lxxix) *The ADNS told us that a new nutritional screening tool was being introduced. The Trust did apologise to Mr C for the deficiencies in the service and told him that measures had been put in place to prevent a recurrence.*

Mouth Care

(lxxx) *I am confident Mrs C received appropriate mouth care. She was a very sick compromised woman who was at risk of breakdown of mucous membrane and skin, and healing would prove to be a problem. It is unfortunate due to the severity of her mouth condition that the nursing records do not provide the evidence of the assessment or the treatment given. However, one of the wards was so concerned they sought the advice of a Dermatologist and appropriate treatment was prescribed.*

Failure to arrange input by nursing specialists in diabetes and colorectal cancer

(lxxxi) *Nurse Specialists in diabetes and colorectal cancer are normally involved with patient education on an outpatient basis.*

(lxxxii) *In Mrs C's case the staff were confident that Mrs C's diabetes was being well managed by the medical staff and they did not see the need to involve the specialist nurse.*

(lxxxiii) *In respect of the colorectal nurse, she was not involved with Mrs C but would have been happy to be involved if asked. In general the staff did not feel there was a need for involving the colorectal nurse. However some said with hindsight it might have been a useful resource to them and perhaps been of support to the family.*

Comment

(lxxxiv) *My opinion is I do not think the involvement of specialist nurses is significant in Mrs C's case.*

Conclusion

(lxxxv) *Mrs C was an extremely sick woman who gradually deteriorated and sadly died. Her medical and nursing needs were extremely complex and she was nursed on a number of busy wards both medical and surgical.*

(lxxxvi) *I believe that most of the nursing staff were attentive to the needs of Mrs C and in general their standards of care were good. However, they did not properly assess Mrs C's nursing needs, draw up appropriate care plans to meet these needs or provide accurate documented evidence of the care they provided.*

(lxxxvii) *It would be my opinion in this case that Mrs C would have been better cared for in HDU at the time requests for this were being made. It would have provided higher nursing ratios and clinical input. I am unsure however whether the ultimate outcome would have been any different in such a sick woman.*

(lxxxviii) *Fluid balance monitoring is haphazard and the importance of this exercise needs to be re-emphasised. The staff failed to pick up on the fact Mrs C was heading for problems regarding fluid overload and how they should have dealt with this. At interview some staff seemed indifferent to its importance.*

(lxxxix) *Poor planning compromised Mrs C's dietary needs. Her medical condition was such that it proved difficult to be consistent with oral intake. Enteral feeding was introduced but this was some three weeks after surgery.*

Mouth Care

(xc) *I would conclude the care given to Mrs C in respect of mouth care was appropriate. Regrettably the attention to recording this care is deficient as is the assessment and the planning.*

General

(xci) *There is scant reference to dialogue with the nursing staff and members of Mrs C's family. It is my opinion that had significant discussions taken place with the family and an understanding of the care and treatment being given explained this complaint would not have been made.*

(xcii) *The crux of most complaints is communication and in this case it seems to have been sadly lacking.*

Recommendations

(xciii) *An interview with the Associate Director of Nursing confirmed that a number of initiatives have taken place all of which were explained and cover many of the shortfalls highlighted, particularly with reference to care planning. These should make a difference provided there is a good audit system in place.*

(xciv) *I would recommend that the Board reviews 'The Essence of Care', an English tool for planning essential aspects of care, and consider whether they could adapt the relevant sections for their own use.*

(xcv) *It is laudable that a new fluid balance form has been produced but until the significance of the content of the form is understood filling them in is a futile exercise. Whilst this element of care is core to the training of nurses;*

I would recommend that the importance of this is highlighted and further education introduced.

(xcvi) *The recording of care is a legal requirement, if it is not recorded there is an assumption it did not take place. The Nursing and Midwifery Council's 'Guidelines for records and records keeping' include that record keeping should be able 'to demonstrate:*

- *A full account of your assessment and the care you have planned and provided [and]*
- *Relevant information about the condition of the patient … at any given time and the measures you have taken to respond to their needs …'.*

(xcvii) *I would recommend that nursing staff be reminded of their responsibility and accountability in ensuring they record care accurately and appropriately.*

(xcviii) *I would recommend that regular discussion with families is seen as an integral part of care and significant discussions are noted.*

Findings

Delay in diagnosis

25. At the start of this investigation the Trust gave an account of the sequence of events in Mrs C's care and said that if the cancer had been present from June 2001 and had it been aggressive it would be expected that there would have been evidence of lymphatic spread on 19 March 2002 when histology from a specimen taken during Mrs C's surgery showed she had a moderately/poorly differentiated adenocarcinoma. I note what the Trust said. I note also that Mrs C had an iron deficiency anaemia in February 2001 shown to be due to blood loss in the gastrointestinal tract. This continued to recur over the next twelve months when a large right sided colonic tumour was found. I am advised that any argument that something else initially caused the iron deficiency anemia and spontaneously disappeared and that a new condition, namely a large inoperable right-sided colon cancer suddenly appeared, lacks credibility. The Trust also said that the biopsy taken on 2 October 2001 showed no specific abnormality. But, as my investigation has shown, although the report of that investigation stated that the terminal ileum (where the small bowel joins the large bowel) had been biopsied in fact the biopsy material was taken from the large bowel. Therefore the finding of no specific abnormality is meaningless.

26. The 1st Assessor explained that diagnosis of right sided large bowel tumours can be very challenging and colonoscopies or barium enemas may have to be repeated on a number of occasions. However, he identified a number of issues which led to delay in the diagnosis of Mrs C's cancer. The first of these was that the initial barium enema (22 June 2001) and colonoscopy (10 July 2001) arranged by Consultant 1 were unsuccessful because of inadequate bowel preparation. The 1st Assessor describes this as not unusual. On 10 July 2001, the plan by the surgeons seems to have been to arrange another colonoscopy and a gastroscopy within four weeks but 15 days later (25 July 2001) Mrs C was admitted as an emergency to a medical ward with significant anaemia. She was discharged on 27 July. The discharge document indicates that the physicians were aware of Mrs C's

ongoing investigations with the surgeons and believed that follow up had been arranged. Consultant 8 does not appear to have been told about Mrs C's admission or discharge which may have alerted him to the fact that Mrs C had not been given a date for the colonoscopy and gastroscopy planned for around 10 August particularly given that the 1st Assessor said the clinical findings would have raised a strong possibility of a tumour in the stomach or large bowel as a possible cause of the anaemia. Consultant 1 returned to work around mid August and he said Mrs C's name was in the file for a repeat colonoscopy with no indication of any urgency. The gastroscopy and colonoscopy did not take place until 2 October, a delay of about 10 weeks.

27. The second colonoscopy (2 October 2001) was reported as normal when in fact the entire large bowel had not been viewed. The terminal ileum had not been reached. The 1st Assessor explained that, on average, this occurs in about 10% of colonoscopies. One foolproof way of establishing whether the whole bowel has been visualised is to biopsy the small bowel and this was recorded as having been done. However, the biopsy report said that the biopsy had come from the large bowel and so it should have been evident that the whole large bowel had not been examined. It is clear from his letter to the Haematology Department dated 16 October 2001 (see chronology at paragraph 5) that Consultant 1 had seen the biopsy result and that he had not picked up from that that the examination of the large bowel was not complete. The 1st Assessor says that at that stage a repeat colonoscopy, a barium enema or a CT colonography should have been arranged given the presence of recurring anaemia, blood in the stool and an incomplete colonoscopy.

28. The 1st Assessor reports that there was further significant delay because of gynaecological investigations and no communications between the two disciplines. Consultant 1 said he decided not to arrange a surgical review until the completion of gynaecological investigations because it was not cost effective to have two teams investigating the same thing. It is my view that Consultant 1 should not have awaited the outcome of the gynaecological investigations before arranging further investigation because examination of the large bowel was not complete. This is demonstrated by the biopsy result which Consultant 1 had seen by

16 October 2001, when he referred Mrs C to the Haematology Department. The letter to Consultant 1 on 14 November (see chronology) from the Haematologists also should have prompted further action. Mrs C was readmitted as emergency on 26 February and a CT scan the following day revealed an abdominal mass.

29. I find that there were wholly unacceptable delays in diagnosing Mrs C's cancer due to a series of errors and failures in communication most of which could and should have been avoided. Consultant 1 missed two clear triggers for further action, which can only be described as errors of judgment. I uphold this aspect of the complaint.

Post-operative care

30. *Whether Mrs C was considered for admission to HDU*: it is clear that consideration was given to admitting Mrs C to HDU on at least three occasions and Consultant 5 acknowledged that on 5 April 2002 there were points when the management of Mrs C in HDU would have been preferable. It has not been possible to establish with certainty, after such a long time, the reasons why Mrs C was not admitted to HDU but it seems likely that it was due to lack of beds. The 1st Assessor explained, that the various episodes of post-operative problems which might have precipitated Mrs C's admission to HDU were stabilised on the ward. Both Assessors are of the view, which I accept, that it is not possible to say whether or not care in HDU would have prevented the complications, which are all recognized potential problems after this type of major surgery, that Mrs C experienced after her surgery. I do not uphold the complaint that Mrs C was not considered for admission to HDU but I note that it would have been preferable to manage Mrs C in HDU from 5 April 2002.

31. *Mouth care*: the 2nd Assessor said that given her condition, Mrs C was at risk of breakdown of the mucous membrane and skin, and healing would prove to be a problem. Mr C was particularly concerned about the mouth care provided for his wife while she was in Ward 5 (28 March to 19 April 2001) which he described as haphazard. The Trust acknowledged that there were periods when mouth care had not been documented but say that other evidence, such as anti fungal treatment and referral to a Consultant Microbiologist and Dermatologist, indicated that nursing staff

demonstrated a clear commitment to care for Mrs C's oral hygiene. However, I note Mr C's evidence (paragraph 6, page 7) that the microbiologist and dermatologist attended because he asked for them, not the nursing staff. The 2nd Assessor has said that she felt confident that Mrs C received appropriate mouth care but said that the nursing records do not provide evidence of the assessment and treatment given. The Nursing and Midwifery Council (the organisation set up by Parliament to protect the public by ensuring that nurses and midwives provide high standards of care to their patients and clients) in the current edition of its publication *Guidelines for records and record keeping* makes the point that:

> `Record keeping is an integral part of nursing … It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow … Good record keeping is a mark of the skilled and safe practitioner, whilst careless or incomplete record keeping often highlights wider problem's with the individual's practice.'

The same publication also comments `The approach to record keeping that courts of law adopt tends to be "if it is not recorded, it has not been done"'. On balance, while I note the 2nd Assessor's view, I am not persuaded that there is sufficient evidence to conclude that Mrs C received appropriate mouth care. I uphold this aspect of the complaint.

32. *Nutrition*: the 2nd Assessor points out that it appeared that some nursing staff, especially on Ward 5, did not seem to recognise their responsibility for patient nutrition and that there was little or no input from nursing staff for the provision of meals. Indeed Mr C says that he saw the failure to provide his wife with the food recommended by the dietician as a matter between the dietician, kitchen staff and hostesses. I have no reason to doubt Mr C's evidence that in Ward 5 in the fortnight after the dietician visited his wife, it was a regular occurrence for the diet recommended by the dietician not to be provided for Mrs C. Mr C should not have had to supplement his wife's meals which he clearly did because of his concerns that she was not receiving enough nourishment. The Trust accepted that Mrs C did not always receive the diet ordered by the dietician

but says that there are numerous references throughout the nursing notes to the fact that diet and oral fluids were encouraged and the Trust considers that all efforts were made to ensure Mrs C's nutritional status was adequate. I agree that there are numerous references to diet being encouraged but there has been no acknowledgement of the importance of ensuring that Mrs C received the type of diet she needed given her mouth condition and general condition. The 2nd Assessor described patient nutrition as a vital aspect of care and concluded that poor planning compromised Mrs C's dietary needs. I am pleased to note that one of the initiatives since taken by the Board is to introduce a new nutrition screening tool to identify any patients at risk of under nutrition and that a Nutrition group has been established to ensure that NHS QIS guidelines on nutrition are met. Nevertheless, I do not consider that these actions alone address the nursing staff's apparent failure to recognise their responsibility for patient nutrition.

33. *Fluid balance*: although fluid balance charts were completed in all the wards, I am concerned by the 2nd Assessor's observation that it was clear that not all nursing staff understood the importance of fluid balance charts and how they should be used.

34. *Specialist nursing care*: the Trust explained the reasons why specialist nurses were not involved in Mrs C's care. The 2nd Assessor's advice, which I accept, was that she did not consider that the involvement of specialist nurses was significant in Mrs C's care.

35. *Communication*: the 2nd Assessor comments on scant reference to significant discussions by nursing staff with Mr C and that communication was sadly lacking.

36. *Ward cleanliness*: Again, I have no reason to doubt Mr C's evidence about the dirty condition of his wife's room while she was in Ward 10. Consultant 5 confirmed during the Trust's investigation of the complaint that he agreed the ward was inadequately cleaned, and the ADNS said that at around that time the hospital had been identified in a report by Audit Scotland (which I have seen) as being in category 4 meaning 'where at least one ward or public area is classified as being of concern or all

wards/public areas show a need for improvement'. As a result a hospital hygiene committee was formed and about a year later, the hospital was judged to be in category 2 meaning 'wards mostly very good or acceptable with one need for improvement'. I endorse the criticism about the cleanliness identified by Audit Scotland. However, I am pleased to note the progress being made in relation to cleanliness at the hospital and consider that the matter is being addressed.

37. *Care planning*: although the day-to-day nursing records were comprehensive, the 2nd Assessor identified in her report that there was no overall comprehensive plan of nursing care and that many of Mrs C's problems and potential problems were not assessed. The ADNS said that it was difficult to find a connection between the care planning and the actual care recorded as given by the nursing staff to Mrs C. I consider that the lack of documentation is likely to have impacted on the quality of overall nursing care given to Mrs C. It is difficult to maintain continuity of care in an environment where staff are coming and going and a patient is moving wards especially in the absence of clear care plans that can be followed by all nursing staff. The ADNS acknowledged that nursing care planning needed to be consistent across the Board and I am pleased to note that, as a result, a senior nurse from the Board has been seconded onto a group looking at care planning across the Board.

38. I uphold the complaint about Mrs C's post-operative care to the extent described above.

Recommendations

39. I welcome the changes already made by the Trust/Board. However, I do not believe that these go far enough to deal effectively with some of the issues highlighted by Mr C's complaint. I make the following recommendations to the Board which include those contained in the 2nd Assessor's report that :

(i) The case is reviewed at the annual appraisal of Consultant 1 as it may indicate that his caseload is too heavy or insufficiently well organised;

(ii) The Board reviews procedures when one Consultant hands over to another;

(iii) The case is reviewed at the gastrointestinal cancer multidisciplinary meeting so that the endoscopists and radiologists can see how such a delay occurred and suggest some safety net mechanism for failed barium enemas and colonoscopies to prevent delays for repeat investigations;

(iv) The Board Governance Committee should discuss this report in terms of the provision of adequate resources to the endoscopy and radiology departments;

(v) There should be an immediate audit of current waiting times and times from referral to diagnosis in colorectal cancer cases;

(vi) The Board consider whether any aspects of the 'Essence of Care' might be adopted by the Board (see paragraph xciv of the 2nd Assessor's report);

(vii) Further education be provided for nursing staff on the significance and importance of fluid balance and the Board carry out intermittent audits of fluid balance monitoring;

(viii) The Board should ensure that all patients have an initial assessment of their nutritional needs and ability to eat and drink. That this should be reviewed whenever there is a significant change in the patient's condition and appropriate care plans put in place when actual or potential problems are identified. The Board should also ensure that patients receive any special diet recommended by dieticians. Ward managers should be responsible for ensuring that all patients are provided with a diet that is appropriate for their individual needs and, if required, assistance is given with eating and drinking;

(ix) Nursing staff be reminded of their responsibility and accountability in ensuring accurate and appropriate record

keeping. Any training or education about record keeping should include issues around the use of nursing records;

(x) Regular discussion with families is seen as an integral part of care and any significant discussions with family are noted. Further that education sessions are provided for nursing staff about issues around communication with patients and their families and how it should be documented, perhaps as part of wider education about complaint handling; and

(xi) Finally, that the Board apologises to Mr C for the failings identified in this report.

Eric Drake
Deputy Public Services Ombudsman
Duly authorised in accordance with
paragraph 11(1) of Schedule 1 to the
Scottish Public Services Ombudsman Act 2002

3 August 2005

ANNEX A

Glossary of medical terms

Aspirating	Suction
Adenocarcinoma	Common type of colon cancer
Anaemia, symptomatic	Haemoglobin (red blood cells), reduced sufficiently to cause symptoms
Anastomosis, primary/ileo-transverse	Joining the small bowel (ileum) to the transverse colon by a surgical operation
Atrial fibrillation	Irregularity of the heart rhythm
Barium enema	An x-ray to outline the structure of the large bowel
Biopsied	Sampled for microscopic analysis
Blood count	Measurement of the haemoglobin, white cell count and platelets
Broncho-pneumonia	Lung infection
Caecum	The beginning of the colon where the small bowel enter it and where the appendix is situated
Calculus cholelithiasis	Gall stone
Chronic Obstructive Pulmonary Disease	The modern term for ‘chronic bronchitis’

Colon	Large intestine
Colon, ascending	The right side of the large bowel
Colon, sigmoid	The left side of the large bowel that leads to the rectum
Colonoscopy	Telescopic examination of the whole large bowel
Colonic mucosa	Lining of the large bowel
Crohn's disease	Inflammatory bowel disease
CT colonography	A method of using a whole-body scanner to visualise the large bowel
Distal metastases	Deposits of cancer at a site distant from the primary site eg in the liver or lungs
Diverticular disease	Small pouches on the large bowel. Common condition
Duke's C2 tumour	Staging nomenclature of colon cancer. 2 is when the wall is invaded but not breached
Duodenum	The length of the bowel leading from the stomach to the small bowel (jejunum)
ECG changes	Changes on the electrocardiogram indicating heart condition
Endoscopist	The operator who performs endoscopy (colonoscopy)

Enterococcus faecalis	Gut bacterium
ESR (erythrocyte sedimentation rate)	When raised indicates a possible infection
Flank pain, right	Pain in the right flank or loin
Flexible sigmoidoscopy	Telescopic examination of the lower bowel
Gastroscopy	Telescope examination of the stomach
GI (gastrointestinal)	Appertaining to the stomach or intestines
Haemoglobin	Red blood cell level
Heart failure	The heart loses its ability to pump blood efficiently
Hemicolectomy, right	Surgical removal of half of the colon
Hepatic flexure fungating tumour	Tumour (cancer) at the bend of the colon by the liver
Hysteroscopy	Procedure to look into the womb (uterus)
Hiatus hernia	A condition in which a portion of the stomach protrudes upwards into the chest through an opening in sheet of muscle that separates the chest from the abdomen
Histology	Microscopic appearance
Hypertension	High blood pressure

Hypoalbuminaemia	Low albumin level in the blood
Iliac fossa	Lower quadrant of the abdomen on the right or left sides over the wing of the pelvis
Ileo caecal valve	Valve between the small bowel (ileum) and beginning of the colon (caecum)
Ileus	Paralysis of the bowel
Inadequate bowel preparation	When faeces remain in the bowel and the examination (colonoscopy or barium enema) cannot be completed satisfactorily
Ischaemic attack	Attack of cardiac ischaemia, that is an episode where the heart muscle has had a temporary lack of blood supply, possibly causing some damage to the heart.
Laparotomy	Exploratory abdominal operation
Moderately/poorly differentiated	Microscopic appearance of a tumour describing the degree of malignancy
Mucosal detail	Details of the bowel lining (mucosa)
Mucosal tumour	Tumour (cancer) of the bowel lining
Nasogastric (NG) feeding	Feeding through a tube passed into the stomach through the nose
Nebulised	Drugs that are delivered to the lungs

	through a mask. Oxygen is bubbled through a solution of the drug which is then breathed in
Oedema of the limbs	Swelling with fluid
Oral thrush	Infection of the mouth with thrush, a fungus, Candida
Parenteral nutrition supplement	Feeding through a vein
PEG (percutaneous endoscopic gastrostomy) feeding	Feeding through a tube passed directly through the abdominal wall into the stomach. Endoscopy is needed for insertion
Pleural effusion	Accumulation of fluid between the layers of the membrane that lines the lungs and chest cavity
Pulmonary embolus	Blockage of a pulmonary artery in the lungs by a blood clot
Pulmonary infection	Infection of lungs
Respiratory failure	Failure of breathing to saturate the blood with oxygen
Resection margins	Edges of bowel after surgical removal of tumour
Sepsis	Severe infection of the blood stream
Tachypnoea	Rapid breathing
Terminal ileitis	Infection/inflammation of the last part of the small bowel (ileum)

Ultrasound	Form of scan using high frequency sonic waves
Urea and electrolytes	Blood test for the levels of sodium, potassium and urea in the blood
Vancomycin	An antibiotic

ANNEX B

List of abbreviations

Abbreviated reference	**Post / location**
CCU	Coronary Care Unit
HDU	High Dependency Unit
The hospital	Hairmyres Hospital
ITU	Intensive Therapy Unit
ADNS	Associate Director of Nursing
Consultant 1	Consultant Surgeon who Mrs C was referred to in February 2001
Consultant 2	Consultant Physician and Cardiologist. Mrs C was admitted as an emergency under his care on 25 July 2001
Consultant 3	Consultant Haematologist saw Mrs C on 14 November 2001
Consultant 4	Consultant Gynaecologist saw Mrs C on 22 November 2001
Consultant 5	Consultant Surgeon in charge of Mrs C's care when she was admitted as an emergency on 26 February 2002
Consultant 6	Consultant Anaesthetist, Acute Pain Team reviewed Mrs C at a ward round on 21 March 2002
Consultant 7	Consultant Surgeon reviewed Mrs C on 30 March 2002

Consultant 8	Consultant Surgeon in charge of Mrs C's care during the period when Consultant 1 was off sick (6 May 2001 to mid August 2001). He also saw her on ward rounds on 31 March and 2 April 2002
SHO	Senior House Officer
SHO 1	Senior House Officer who carried out the colonoscopy on 10 July 2001
SHO 2	Senior House Officer who carried out the gastroscopy and colonoscopy on 2 October 2001
SHO3	Senior House Officer in Gynaecology who saw Mrs C on 19 November 2001
Staff Grade 1	Staff Grade in Surgery present at the gastroscopy undertaken on 20 October 2001 and he performed the operation on 19 March 2002
Sister 1	Sister in charge of Ward 2
Sister 2	Sister in charge of Ward 5
Sister 3	Sister in charge of Ward 10
Staff Nurse 1	Staff Nurse in Ward 2
Staff Nurse 2	Staff Nurse in Ward 2
Staff Nurse 3	Staff Nurse in Ward 5
Staff Nurse 4	Staff Nurse in Ward 5
Staff Nurse 5	Staff Nurse in Ward 9

Staff Nurse 6	Staff Nurse in Ward 9
Staff Nurse 7	Staff Nurse in Ward 10